U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 November 2005

Case No.: 2004-BLA-06371

In the Matter of:

RUTH BANKS, Widow of
ELI BANKS, Deceased
Claimant

v.

BRIGHT COAL COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

William Roberts, Esq.
For the Claimant

Denise M. Davidson, Esq.
For the Employer

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for survivor's benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of

the deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

Employer requested a hearing before this Office on March 24, 2004 (DX 36[1]), following the determination by the Director, Office of Workers' Compensation Programs (OWCP) that Claimant was entitled to survivor's benefits issued on February 27, 2004 (DX 31, 34). The claim was referred to this Office on June 8, 2004 (DX 41).

The record includes Director's Exhibits 1 through 43 which I failed to enter into the record at the April 6, 2005 hearing and which are hereby entered into evidence. In addition, Claimant's exhibits 1 though 4 and Employer's exhibits 1 and 2 were admitted into evidence at the hearing. Subsequent to the hearing, pursuant to agreement at the hearing, Employer has submitted the April 15, 2005 report of Dr. R. Naeye which is hereby admitted into evidence as Employer's Exhibit 3 and Claimant has submitted a medical statement by Dr. J. Simpson dated May 3, 2005 which is hereby entered into evidence as Claimant's Exhibit 5. In subsequent communication, both parties objected to the newly submitted evidence of the other party. Claimant objected to Dr. Naeye's report to the extent it included discussion of medical evidence other than his review of the lung slides. Employer objected to Dr. Simpson's report as rehabilitative evidence for Dr. Bensema's pathological report. I have reviewed the parties objections and reject the objections. Rather, I will take their arguments into account when considering the weight to accord to the respective evidence. Evidence summary forms by the parties were admitted as Administrative Law Judge Exhibits 1 and 2.

Procedural History

Claimant's husband filed a claim for miner's benefits on June 7, 1973 which was initially granted on December 5, 1979. However, in an undated Revised Notice of Initial Finding, benefits were denied since the miner was continuing active work in coal mine employment (DX 1 at 282). On March 13, 1986 the miner filed a second claim for benefits which was denied by the District Director on April 5, 1988. The District Director found the presence of pneumoconiosis was established, but found the evidence did not establish total disability due to pneumoconiosis (DX 1 at 431). Claimant did not appeal the denial and the case was administratively closed. Following the miner's death on June 14, 2002, his widow filed this claim for survivor's benefits on June 4, 2003 (DX 3).

Applicable Law

Claimant filed her claim on June 4, 2003 (DX 3). Therefore, entitlement to benefits must be established under the regulatory criteria at Part 718. Section 718.205(a) provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis which arose out of coal mine employment. An eligible survivor will be entitled to benefits if claimant proves that: 1) The miner had pneumoconiosis; 2) The miner's pneumoconiosis arose out of coal

[1] The following abbreviations will be used as citations to the record: DX – Director's exhibits; CX – Claimant's exhibits; EX – Employer's Exhibits; and TR – Transcript of the April 6, 2005 hearing.

mine employment; and 3) The miner's death was due to pneumoconiosis as provided by Section 718.205. For purposes of claims filed after January 1, 1982, death will be considered due to pneumoconiosis if any of the following criteria is met: 1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; or 2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death; or 3) Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable. 20 C.F.R. 718.205(c). The regulations also provide that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. 718.205(c)(4). The regulations further provide that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. 20 C.F.R. 718.205(c)(5).

The parties agreed that the evidence establishes the deceased miner worked as a miner for at least forty (40) years in coal mine employment, that the claim was timely filed and that the named Employer is the Responsible Operator . At the hearing, The Employer argued, however, that the evidence of record does not establish that the miner had pneumoconiosis which arose out of coal mine employment or that the miner's death was due to pneumoconiosis under any of the provisions set forth in Section 718.205(c).

Death Due to Pneumoconiosis

The record in this survivor's claim includes the medical evidence submitted with the miner's claim and set forth in the District Director's determination of April 5, 1988 and that description is adopted by reference herein (DX 1). In addition, the following medical evidence has been submitted:

Records from the miner's hospitalization in October, 1996 indicate he was treated for squamous cell cancer in the left main stem bronchus with a left pneumonectomy. The admitting diagnosis noted the presence of coal worker's pneumoconiosis. The pathological report by Dr. Bensema identified squamous cell carcinoma and, on microscopic examination, reported the sections away from the tumor showed fibrous plaque with black anthracotic type pigment and some refractile material compatible with silica (DX 14, 15). In October, 2001, the miner had surgery for a mass in his right kidney.

Treatment records from Dr. M. Bielecki establish she began treating the miner in October, 1996. She referred the miner to Dr. Gerhardstein, a pulmonary specialist. As noted above, the miner was diagnosed with lung cancer and his left lung was removed surgically in October, 1996. Dr. Bielecki continued to follow the miner, noting he made a good recovery from the surgery and continued to keep active. Dr. Bielecki's notes also indicated he occasionally exerted himself beyond reasonable activities. Dr. Bielecki also noted the miner's strong will regarding resistance to medical treatment. She demonstrated a thorough and caring concern regarding his decision to forego chemotherapy or radiation treatment following the lung surgery in 1996 or the kidney surgery in 2001. As his condition deteriorated, Dr. Bielecki admitted the miner to hospice care in April, 2002. During home visits in May and June, 2002, she noted his continuing problems with shortness of breath and swelling (DX 13).

Dr. Bielecki signed the death certificate following his death on June 14, 2002 and listed the cause of death as squamous cell lung cancer. Dr. Bielecki listed other significant conditions contributing to death as renal cell carcinoma and chronic obstructive pulmonary disease. In January, 2003, after reviewing additional records from 1986 and 1987 provided to her by the miner's family, Dr. Bielecki stated she signed an addendum to the death certificate which included pneumoconiosis as an "other significant condition contributing to death". (DX 16). In the January 13, 2003 report, Dr. Bielecki stated it was her opinion the miner's occupational lung disease was caused by his coal mine employment of more than 43 years based on his significant exposure and the chest x-ray records which documented pneumoconiosis. Dr. Bielecki stated she did not make this diagnosis, but rather she relied upon the physicians who had diagnosed pneumoconiosis previously. Dr. Bielecki stated she is board certified in family medicine, but she does not have the certification to do black lung or pneumoconiosis classifications of chest x-ray films. Dr. Bielecki's diagnoses of the miner's condition was: 1) squamous cell carcinoma of the left lung, status post pneumonectomy in October, 1996; 2) pneumoconiosis; and 3) chronic obstructive pulmonary disease. Dr. Bielecki stated it was her opinion the pneumoconiosis and chronic obstructive pulmonary disease were related to the miner's occupation. Dr. Bielecki stated further the miner's chronic lung disease was due in part to his coal mine dust exposure, however, she noted multiple factors contributed to his chronic lung disease. As a family practitioner, Dr. Bielecki stated she is not able to distinguish the effect of coal mine dust exposure and cigarette smoking, however, it was her opinion the miner died a respiratory death which was due to both pneumoconiosis and lung cancer (DX 12).

At a deposition taken on November 10, 2003, Dr. Bielecki stated she is board-certified as a family physician and began treating the miner in October, 1996 for shortness of breath and an abnormal chest x-ray. She referred him for treatment to a pulmonary specialist and squamous cell lung cancer was diagnosed. As noted above, this serious lung cancer was treated quickly by a pneumonectomy as noted above. In 2001, when the miner had blood in his urine, she referred him for treatment and he had surgery for renal cell carcinoma. She stated she added the diagnosis of pneumoconiosis to the death certificate after reviewing records from 1986 and 1987. Dr. Bielecki reiterated that she did not diagnose pneumoconiosis, but based on the evidence from pulmonologists and radiologists she determined it was appropriate to add to the death certificate that pneumoconiosis was a contributing factor in the miner's pulmonary death. Dr. Bielecki acknowledged that pneumoconiosis was not listed on the October, 1996 chest x-ray which demonstrated the initial lung cancer. Dr. Bielecki also stated her treatment for the miner's chronic obstructive pulmonary disease was the same as it would have been for pneumoconiosis for this miner with very sick lungs and poor pulmonary reserve. Dr. Bielecki also stated that the miner's coal mine dust exposure contributed to his poor pulmonary function and she added she accepted Dr. Gerhardstein's pulmonary analysis and diagnosis of pneumoconiosis (DX 16).

On March 16, 2005, Dr. Bielecki reviewed additional records. She stated Dr. Fino's report of May, 2004 did not change her mind regarding the diagnosis of pneumoconiosis. Dr. Bielecki noted the biopsy report by Dr. Bensema supported a diagnosis of pneumoconiosis. Dr. Bielecki stated the evidence supports a finding that pneumoconiosis contributed to the miner's death based on the evidence of pneumoconiosis including Dr. Bensema's pathological review

and Dr. Vuskovich's x-ray report and based on her experience as the miner's treating physician from October, 1996 through his death in June, 2002 (CX 4).

On November 12, 2003, Dr. T. Jarboe, a pulmonary specialist, reviewed the miner's medical records. Dr. Jarboe stated the miner's death was not contributed to, caused by or hastened by coal worker's pneumoconiosis based on clinical, pathological, physiological and radiological evidence. Dr. Jarboe stated there was no diagnosis of pneumoconiosis during the miner's life by his treating physician. Dr. Jarboe also stated the pathological examination following the miner's lung surgery in October, 1996 noted some findings of pneumoconiosis but not a specific diagnosis of pneumoconiosis. Dr. Jarboe noted pulmonary function study and blood gas studies in 1986 were normal. Dr. Jarboe stated these tests would have had to show a significant impairment for pneumoconiosis to cause, contribute to or hasten the miner's death. The fact the miner was able to perform yard work following lung surgery also demonstrated the miner's functional capacity after surgery was not consistent with pneumoconiosis serious enough to contribute to or hasten the miner's death. Finally, Dr. Jarboe noted the radiographic evidence was negative for pneumoconiosis severe enough to have caused death and CT scans showed no significant pneumoconiosis (DX 19). In a report dated November 13, 2003, Dr. Jarboe stated the chest x-ray of October 7, 2001 was negative and the CT lung scan of April 18, 2002 showed no evidence of pneumoconiosis (DX 20). At a deposition taken on November 14, 2003, Dr. Jarboe stated the presence of pneumoconiosis could be ruled out based on his own negative x-ray and CT scan readings and Dr. Wiot's negative x-ray and CT scan readings. Dr. Jarboe stated the cause of the miner's death was the recurrence of carcinoma, noting the miner had left lung carcinoma in 1996, kidney carcinoma in 2001 and a new lung carcinoma in the right lung in 2002. Dr. Jarboe stated the squamous cell carcinoma is almost always due to cigarette smoking (DX 21).

Dr. G. Fino, a pulmonary specialist, reviewed the miner's medical records on May 7, 2004. Dr. Fino noted that at the time the miner left coal mine employment in 1986 he had no respiratory impairment. Dr. Fino stated he agreed with Dr. Bielecki that the miner died a respiratory death, however, Dr. Fino stated the miner's death was due to metastatic lung cancer. Dr. Fino stated there is no objective evidence prior to 1996 which shows any respiratory impairment or pulmonary condition due to either cigarette smoking or coal mine dust exposure, thus, all the respiratory problems which arose were the result of the miner's lung surgery in 1996, according to Dr. Fino. He stated that even if simple coal worker's pneumoconiosis were present, there is still no objective evidence of disability or impairment due to coal worker's pneumoconiosis and all the evidence shows the miner's lung impairment and/or disability was due to cigarette smoking and resultant lung cancer. Dr. Fino concluded: 1) there is insufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis; 2) there is no respiratory impairment due to coal mine dust exposure and the evidence shows no respiratory impairment until after the pneumonectomy in 1996; 3) from a respiratory standpoint, the miner was disabled from coal mine employment due to the removal of his left lung due to smoke-induced lung cancer; 4) even if coal worker's pneumoconiosis were present, it did not contribute to his disability; 5) the miner's death was due to smoke induced lung cancer and coal mine dust exposure did not contribute; and 6) the miner would have died at the same time even if he had never worked in coal mine employment (EX 1).

In a surgical pathological report dated November 29, 2004, Dr. Bensema, a board-certified pathologist, reviewed the lung samples from the miner's left lung surgery in October, 1996. Dr. Bensema reported the left lung sample showed evidence of pneumoconiosis. Dr. Bensema also reported the presence of fibrosis in some nodules which suggested complicated pneumoconiosis with early progressive massive fibrosis. Dr. Bensema stated this evidence must be considered with chest x-ray readings to determine if more extensive fibrosis and larger nodules were present which would support a diagnosis of complicated coal worker's pneumoconiosis and progressive massive fibrosis. Dr. Bensema reported the lung tissue uninvolved with the tumor showed evidence of coal worker's pneumoconiosis with macules and nodules in the lung parenchyma and with black anthracotic pigment and refractile material complete with silicates identified with polarized light. In the areas of fibrosis associated with the nodules, the largest is slightly less than 1.0 centimeters in the lung parenchyma and one pleural nodule was 1.5 centimeters in diameter (CX 2).

On April 15, 2005, Dr. R. Naeye, a board-certified pathologist, reviewed the medical records and the lung slides. Dr. Naeye noted the miner had normal pulmonary function according to the pulmonary test results in November, 1986 and normal blood gas study results in 1999 and 2002. Dr. Naeye stated the lung slides' most striking abnormality was the poorly differentiated squamous cell carcinoma but he stated that a moderate amount of black pigment, some associated with fibrosis, was also present. Dr. Naeye also stated there were a few very tiny birefriengent crystals of toxic silica. He stated none of the anthracotic areas reached 2 centimeters, so there was no evidence of complicated coal worker's pneumoconiosis. Dr. Naeye concluded a diagnosis of simple coal worker's pneumoconiosis was appropriate, however, based on the pulmonary function studies, the blood gas studies and the anatomic findings, the coal worker's pneumoconiosis present did not cause clinically significant abnormality or contribute to the miner's death. Dr. Naeye then discussed the medical literature which is very clear that lung cancer is not related to coal mine employment or coal mine dust exposure (EX 3).

In addition to these medical reports, Drs. Jarboe and Wiot (twice) read an x-ray film taken on October 7, 2001 as negative for pneumoconiosis and Dr. Vuskovich found evidence of pneumoconiosis, 1/0 q, q, on this same x-ray film. The record also included numerous x-ray reports from the miner's hospitalizations. In addition, Dr. Jarboe and Dr. Wiot reported no evidence of coal worker's pneumoconiosis on a CT scan taken on April 18, 2002 (DX 15, 18, 20, CX 1, EX 2).

Although Employer contested the issue of the presence of pneumoconiosis at the hearing, in its brief of July 5, 2005 appeared to agree that the biopsy reports of Drs. Bensema and Naeye, which both agreed there was pneumoconiosis present, are sufficient to establish the presence of pneumoconiosis in this case.

I find the biopsy evidence persuasive and find it lends strong support to the diagnosis of the miner's treating physician who diagnosed pneumoconiosis based on a review of previous records and who confirmed that diagnosis upon review of the biopsy report. In addition, the report of miner's treating physician, Dr. Bielecki, must be considered pursuant to §718.104(d). This new regulation in effect states that a treating physician's opinion shall be accepted "in the absence of contrary probative evidence" and may be given controlling weight if it is credible "in

light of its reasoning and documentation, other relevant evidence and the record as a whole." §718.104(d)(5). Dr. Bielecki's treatment notes document a close relationship with the miner, with frequent visits, including home visits when he was unable to come into the physicians' office. In addition, Dr. Bielecki treated the miner regularly over a six-year period for serious lung cancer and renal cancer. Her notes demonstrate her close relationship with the miner since she often referred to specific advice she gave to this miner in recognition of his strong-willed nature, his hesitation to seek medical advice, and his desire to avoid extensive additional medical treatment following the first lung cancer and later kidney cancer. Although there is contrary evidence of record regarding the presence or absence of coal worker's pneumoconiosis, I find Dr. Bielecki's diagnosis of pneumoconiosis as based on the prior positive x-ray films, the miner's work history and the positive biopsy report is well reasoned, well documented and, thus, entitled to controlling weight. In addition, I find the uniformly positive biopsy reports outweigh the contrary negative chest x-ray readings and the contrary medical review reports of Drs. Jarboe and Fino. I find, therefore, the persuasive biopsy reports and the reports of the miner's treating physician are sufficient to establish the presence of pneumoconiosis under the provisions of Section 718.202(a)(2) and (a)(4).

Dr. Bielecki also attributed the miner's death, in part, to pneumoconiosis based on the fact he died a respiratory death and had very poor pulmonary reserve prior to his death due to the lung cancer and previous surgery, chronic obstructive pulmonary disease and coal worker's pneumoconiosis. While I note Dr. Bielecki did not diagnose pneumoconiosis during the time she treated the miner, I also find persuasive her statements that she is not qualified to diagnose pneumoconiosis by chest x-ray and her treatment of the miner's pulmonary problems would not have varied with the additional diagnosis of pneumoconiosis along with the diagnoses of lung carcinoma and chronic obstructive pulmonary disease.

Drs. Jarboe, Fino and Naeye all conclude the miner's pneumoconiosis did not contribute to his death, in part because he did not demonstrate pulmonary disability prior to his lung surgery in 1996. These physicians have not explained, however, why pneumoconiosis, which has clearly been established in this case, could not have progressed after 1996 to the point where it was a contributing factor in the miner's death.

Dr. Jarboe stated the pneumoconiosis present was not severe enough to have caused, contributed to or hastened death. In his November, 2003 deposition, Dr. Jarboe stated the presence of pneumoconiosis could be ruled out. Thus, Dr. Jarboe's reports and statements are not entirely consistent on whether or not pneumoconiosis was present. As noted above, however, I find Dr. Jarboe's report regarding the presence of pneumoconiosis outweighed by the biopsy reports which clearly and conclusively established the presence of pneumoconiosis. In evaluating Dr. Jarboe's findings that pneumoconiosis did not contribute to the miner's death, I accord less weight to his conclusions on this issue. It is not entirely clear whether or not this conclusion is based on Dr. Jarboe's statement at deposition that pneumoconiosis could be ruled out. However, even to the extent it is based on the lack of pulmonary impairment prior to the miner's lung surgery in 1996, Dr. Jarboe has not explained why the pneumoconiosis could not have progressed from 1996 to 2002 and been a contributing factor in the miner's pulmonary death.

Similarly, Dr. Fino's opinion is based primarily on his finding that pneumoconiosis was not present, or even if it was, it had caused no disability and, thus, did not contribute to the miner's death due to lung cancer. Dr. Fino's opinion is accorded less weight since his finding that pneumoconiosis is not present is contrary to the conclusions reached in this case. Although he stated that even if coal worker's pneumoconiosis was present, it did not contribute to the miner's disability, he did not discuss the basis for this statement in detail other than the fact the miner's pulmonary disability was not established until after the 1996 pulmonary surgery. Dr. Fino has not explained why pneumoconiosis could not have progressed and added to the miner's pulmonary disability due to pulmonary surgery and lung cancer. Dr. Fino has also not explained why the miner's pulmonary death could not be due to his multiple pulmonary problems, includeing lung cancer, chronic obstructive pulmonary disease and coal worker's pneumoconiosis.

Dr. Naeye also concluded that coal worker's pneumoconiosis did not contribute to the miner's death in light of his review of the pulmonary function study results of 1986 and the blood gas study results. He does not, however, explain why the pneumoconiosis which was present could not have progressed or added to the miner's pulmonary condition by the time of the miner's death. The main point in Dr. Naeye's discussion, that coal mine employment does not cause lung cancer, has not been contested in this case. Neither Dr. Bielecki nor any other physician has argued that the miner's lung cancer was caused, in part, by coal mine dust exposure or coal worker's pneumoconiosis. Rather, Dr. Bielecki has stated that the miner's pulmonary death was due to a combination of his pulmonary problems, lung cancer, chronic obstructive pulmonary disease and pneumoconiosis and, further, that both the chronic obstructive pulmonary disease and coal worker's pneumoconiosis were due to the coal mine dust exposure.

Dr. Bielecki's conclusion that pneumoconiosis, lung cancer and chronic obstructive pulmonary disease all contributed to the miner's poor pulmonary reserve and pulmonary death is well supported by her status as the miner's treating physician as well as the biopsy reports which clearly established the presence of pneumoconiosis. Dr. Bielecki's finding that pneumoconiosis was a contributing factor in the miner's pulmonary death is well supported by her close treatment of the miner, especially during his last few months. Dr. Bielecki noted the miner's poor pulmonary reserve due to the previous lung cancer and surgery, chronic obstructive pulmonary disease and coal worker's pneumoconiosis. She has stated she is not able to separate out the effect of each of these pulmonary problems, but she has established a clear basis for each diagnosis. Her conclusions are not contradicted by contrary probative evidence and, therefore, as the miner's treating physician they are entitled to controlling weight. I find, therefore, Dr. Bielecki's opinions are sufficient to establish the miner's pneumoconiosis contributed to his death.

I find the medical evidence is not sufficient to establish the presence of complicated pneumoconiosis. Dr. Bensema did note some changes on the biopsy slides which may indicate complicated pneumoconiosis was present. However, she also stated these changes would need to be considered in light of chest x-ray findings of lung changes prior to a diagnosis of complicated pneumoconiosis. Since none of the chest x-ray readings of record indicate any changes of complicated pneumoconiosis, Dr. Bensema's statements are not sufficient to establish complicated pneumoconiosis.

Thus, on review of the medical evidence, there is no evidence that pneumoconiosis caused the miner's death, so death due to pneumoconiosis is not established under subsection 718.205(c)(1). Furthermore, for the reasons set forth above, the evidence does not establish the presence of complicated pneumoconiosis and, therefore, pneumoconiosis is not established under the provisions of subsection 718.205(c)(3). However, I find Dr. Bielecki's opinion is sufficient to establish that pneumoconiosis contributed to the miner's death for the reasons set forth above. Therefore, Claimant has established the miner's death was caused by pneumoconiosis pursuant to subsection 718.205(c)(2).

Claimant has established the miner's death was due to pneumoconiosis under the provisions of Section 718.205(c) and, accordingly, she is entitled to survivor's benefits under the Act. Claimant's benefits shall commence June 1, 2002. 20 C.F.R. §725.503(c).

ORDER

Bright Coal Company is hereby ORDERED to pay to Ruth Banks, widow of Eli Banks, all survivor's benefits to which she is entitled under the Act, commencing June 1, 2002.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).